NURSING IN NERVOUS DISEASES

THIRD PAPER

NURSING IN STATES OF DEPRESSION

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DEPRESSION is an alteration of emotional tone, of mood. Our moods are but expressions of our reaction to occurrences of the world in which we live. The emotional tone is a sounding-board which reflects the influences which come to us from outside. The normal man reflects in his mood something from all the influences which come into his life, and his personality depends, in great measure, on what influence his sounding-board is tuned for with greatest sensitiveness. He who reflects the happy incidents of life, more than the sad ones, is the optimist, while the pessimist is tuned for the dark unpleasant ones by preference. The irascible short-tempered man reflects mostly the irritating, exasperating side of life, and him who is attuned mainly to the uncertain, the fearful, we call timid.

In pathological depression our sounding-board is all out of tune and responds to nothing except that which is sad. Of the manifold impressions coming from the outer world only the sad unpleasant ones find response in the depressed patient; he can see nothing but the dark side of life, sinks to the depth of despondency under the weight of his great sorrow, is, in other words, depressed.

Of the pathological depressions, the ones most frequently met with are those accompanied by retardation, and those accompanied by anxiety. The depression with retardation is the depressive phase of manic-depressive insanity. This disease, manic-depressive insanity, occurs in two phases of diametrically opposite character; the manic phase with increased activity in the mental and physical fields and the depressed phase which we will consider here. The patient in this depressed phase presents a picture of the most extreme dejection. He is slow of speech and of motion, preferring to sit quietly in one position with bowed head and an expression of infinite sadness. When roused he moves slowly and in a disinterested manner. He speaks but little and answers questions in a slow sad voice, one word following the other with apparent effort. This is the true melancholia and all that that word means applies to the manic depression. The mental field shows the same slowness, retarda-

tion, as the physical. The patient's outlook is gloomy and hopeless in the extreme. Nothing interests him, for he is absorbed in the sadness of his own condition. He complains little, for he considers no one to blame for his condition but himself. He thinks continually of himself as bad, lazy, and vile, rather than sick, and feels that he is a burden to those about him, bringing nothing but trouble and sadness to those who care for his unworthy self. He looks forward to no betterment in his condition, loses faith in his doctor and sees no relief except in death. Not infrequently these patients suffer from delusions in that they believe they have committed "the unpardonable sin" for which death alone can atone. Hence these patients frequently commit suicide and, in fact, make up a very large percentage of the suicides of the world.

Depression with anxiety presents a very different picture. Depression of this sort occurs most frequently in neurasthenia, hysteria, at the menopause (involution melancholia) and at times in paranoia. These patients are anxious and worried about their health. They feel themselves to be sick, suffering from a serious bodily disease and desire to be helped. They crave sympathy and seem to enjoy talking about their symptoms and troubles. They worry continually and observe the slightest symptoms, each one of which increases their worry. There is none of the retardation, mental or physical, for every unusual occurrence startles and irritates them. Loud noises, unpleasant sights, a rainy day all make a deep impression on them and increase their worry concerning their health.

A patient suffering from a manic depression should be left alone in the early stages of the disease. The nurse should remember that she is dealing with a definite disease which must run its course and that recovery cannot be hurried by trying to interest the patient in anything. All that is needed is rest in bed, in quiet surroundings, until the interest begins to awaken. With the agitated depression, interest can be stimulated from the start and here, as in the convalescence from manic depression, there exists a great opportunity for work of real therapeutic value on the part of the nurse. Methods for the development of interest, occupation therapy, reading, nature study, etc., deserve a chapter to themselves and cannot be entered into here. It may be said in passing, however, that, especially in depressed cases, there is great necessity of finding something which appeals to each patient from a personal standpoint. Each patient must be studied, and an occupation bearing some relation to the patient's home or past life will generally give the best results.

Of the special symptoms of depressed states, refusal of food is one of

great importance. This is present by far most commonly in the manic depression. The reasons why depressed patients refuse food are usually a desire to die or a fear of poisoning. Others may refuse merely from lack of interest in life or, as one occasionally sees in manic depression where ideas of self-accusation are prominent, from a fear that in eating they may thereby be depriving others more worthy than themselves of the necessities of life. Naturally when patients refuse food they must be induced to eat or else to be fed. Many patients may be coaxed to eat, and here much depends on the personality of the nurse and one nurse will often be successful where another has failed. If the patient cannot be induced to eat he may submit to being fed. This is often the case where indifference is the cause of the fasting. Liquids and soft foods are always taken more readily than solids as they require less effort on the patient's part. If feeding is not possible, then one may try leaving the patient completely alone with a tray full of food. Often, when this is done, the nurse returning a half hour later finds that the patient has finished the meal; or food may be left around conveniently for the patient to take when he feels like it. In any case every possible means and strategy must be tried before refuge is taken in forced feeding.

When all other means have failed, and only then, is forced feeding to be resorted to, and in a fairly strong individual not before the patient has fasted at least forty-eight consecutive hours. Forced feeding with a stomach-tube is properly the duty of the physician, but as there are conditions in which it may fall upon the nurse, it is well to describe the technic here.

In feeding with the stomach-tube, the tube may be passed through the mouth or the nose. The former way has many disadvantages but will be spoken of here very briefly. If the patient is at all sensitive it is best to have him in the recumbent position. Always have plenty of help at hand so that all resistance may be overcome or that the patient may see that resistance is useless. Before proceeding with the first feeding explain to the patient what you are going to do and why; not with the idea of frightening the patient but of inducing him to eat voluntarily. Explain to him that it is unpleasant and that if he will drink a sufficient quantity of the feeding mixture you will not force it on him. Be sincere and firm about this and if he takes you at your word, keep it strictly. Some patients can be induced to eat in this way.

The technic of passing a stomach-tube by mouth belongs to the domain of general nursing and needs only brief mention here. The patient is firmly held in bed and the mouth is forced open with a screw

gag and held. Then the tube, which has been lying in ice water, is passed slowly into the stomach; taking care to avoid the larynx. Of the disadvantages of this method the most important are the danger of breaking the teeth and lacerating the mouth with gags, and the danger of the patient biting off and swallowing lengths of the tube. These dangers are so great and serious that the method is not to be recommended and should never be used except in weak and non-resistive patients when nasal tubing is impossible.

Passing the tube by way of the nose is by far the better way, as the dangers mentioned above are obviated and resistance on the part of the patient is more easily overcome. The patient is placed in the recumbent position and held so that resistance is ineffectual. Usually it is not necessary to hold the head securely, but in strong patients the head may be held by placing a folded towel over the forehead and having the ends held firmly on the bed at either side of the head. The tube to be used here should be smaller than those generally used in passing through the mouth; size 26 to 30 on the French scale. It is first well coated with vaseline and passed into one nostril, after first lifting the tip of the nose. The tube is passed directly backward and usually goes easily until the posterior pharyngeal wall is reached. If, however, an obstacle should be encountered which cannot be passed by gentle pressure, withdraw the tube and repeat on the other side. In most persons one nostril is larger than the other and this should be chosen. Pass the tube slowly until the posterior pharyngeal wall is reached and the tube stops. Then a slight increase of pressure will deflect the tip of the tube downward; continue passing slowly until the tip has entered the œsophagus, when the tube can be more rapidly passed down to the stomach or until the white mark on the tube is just within the nostril.

Very resistive patients, especially those who have refused food from a desire to die or from a fear of poisoning, will adopt many and often ingenious means to frustrate your efforts and often the longer these patients are fed with the tube the more expert they become in their resistance. As the mouth is free, these patients frequently take recourse in spitting at the attendants. A towel or piece of gauze held very lightly over the mouth will prevent this and not interfere with the patient's breathing. Some patients, who have been tube fed for a time and are still resistive, will develop the unpleasant trick of bringing the tip of the tube into the mouth. They do this by dropping the tongue well back into the throat and, when the tip of the tube pushes on the tongue, elevate it again into the mouth, bringing the tube with it. Then

any further pressure on the tube forces it into the mouth up to the teeth when the patient will grip the end firmly in the teeth so that it cannot be moved one way or the other. When this happens, don't pull on the tube, for it cannot be pulled from between the teeth and the pulling damages the delicate tissues of the floor of the nose and of the palate. Hold the free nostril and the lips together firmly with the finger so as to impede easy respiration, and when the patient gasps for breath the tube may easily be withdrawn into the pharynx and started on the right track. Other patients, and fortunately one seldom sees them, becoming more resistive the longer they are fed, learn how to force the tube into the larynx. They do this so purposefully that one cannot help but think that they do it with a realization that you will not force the food on them when the tube is in the trachea. The patient who forces the tube into the larynx does so by throwing his head back as far as it will go, thus making a straight line between the larynx and the pharynx, rather than between the œsophagus and the pharynx. When a patient does this, pass the tube slowly until the tip is well into the pharynx. Then standing on the right of the patient place your left arm under his head so that the bend of the elbow is caught at the back of the head and forcibly but slowly bend the head forward until the chin touches the chest. By this means the larynx is thrown out of line and the tube may be rapidly passed into the œsophagus with little trouble. No matter what resistance the patient may offer, never give up. The patient must be fed to keep him alive, and each time you fail makes the next attempt all the harder. With enough assistance to overcome resistance any patient can be tube-fed providing there are no pathological conditions which prevent the passing of the tube.

Having passed the tube, it is necessary to be sure that it is in the stomach before pouring in the food mixture. When the tube has been passed into the trachea the patient gags, becomes cyanotic, struggles wildly, yet is unable to talk or make any outcry owing to the presence of the tube between the vocal cords, and one can hear the breathing through the tube. If in doubt as to where the tube is, you may be assured that it is not in the patient's trachea, if he is able to use his voice. When the tube is in the stomach, the feeding mixture is poured into the funnel and allowed to run into the stomach by gravity. When the feeding is finished the tube is withdrawn rather rapidly, being sure to pinch the tube well so that none of the fluid in the tube can run into the larynx or the nose.

Naturally, liquid food alone can be used, and we employ milk, beef

broth, infants' foods, or milk and raw eggs mixed. A very serviceable mixture consists of one quart of milk, containing four to six eggs, given twice a day. This will keep a patient alive for months.

Of the special symptoms in tube-fed cases, bleeding from the nose and nasal inflammation are not uncommon. These may be avoided in great measure by care in passing the tube and by using plenty of vaseline in lubricating the tube. Constipation is combated with liquid purgatives, castor oil, salines, etc., which are poured down the tube before the feeding mixture. Cases that have been fed for a long time frequently develop a severe gastritis. This condition manifests itself by foul breath, coated tongue, and vomiting of the feeding mixture. The vomitus contains also much mucus and green curds. The procedure in these cases is first to wash the stomach with warm normal saline solution until the return fluid is perfectly clear; then the feeding mixture will be retained. Some patients who are very determined in their resolution to fast, will voluntarily vomit the mixture as soon as the tube is withdrawn. In this case start all over again immediately. Pass the tube again and give another dose of the mixture, and after withdrawing the tube hold the mouth closed for a minute until the period of nausea is passed. This will generally suffice, but in any case repeat the feeding as often as the patient vomits it, until one is retained. The most resistant patient tires of the process after two or three feedings. A severe complication from tube feeding, which in some cases appears unavoidable, is bronchitis and bronchopneumonia. It results from getting some of the feeding mixture into the lungs and is more easily prevented than cured. When it does occur it requires the ordinary care of inspiration pneumonia.

There remains one other method of forced feeding by mechanical means, *i.e.*, rectal feeding. This is indicated only when the stomach tube cannot be passed or when the stomach is so deranged that all mouth feeding is impossible. It is so rarely necessary that it hardly deserves mention here, and the subject is well covered by books on general nursing.

Another special symptom, requiring the nurse's constant care, which belongs to the depression and especially to the depressed phase of manic depressive insanity, is the desire for suicide. Any depressed patient may attempt suicide either from sheer despondency over the outlook for the future or from feelings of unworthiness. Suicide is generally attempted by strangulation, suffocation, poisoning or injury. Strangulation is accomplished by hanging from chandelier, transom of door, etc., with cords, bed clothing or personal clothing, or the patient may reach the same end by tying one end of a sheet around the neck and the other to the

head of the bed and then slipping down under the covers until the body hangs mostly out of the bed. Suffocation is seen in suicides with illuminating gas and by drowning. The poison used may be of anything; broken glass, rat and bug poison, paint, carbolic acid, etc., anything in fact that the patient can get hold of and which is considered poisonous. Among the personal injuries are cutting and stabbing with knives, paper cutters, broken glass, nails, etc., and jumping from windows.

Naturally the main thing in the treatment of suicide is prevention. All depressed cases and especially those suffering from the manic depression should be under constant watch with a view to prevention of suicide. This watching is especially necessary at night and in the early morning hours, for it is then that the depressed patient is at his lowest ebb and most apt to attempt suicide. Never allow one of these patients to lie in bed for any length of time with head covered, and never leave them alone. All sharp or pointed implements, such as knives, scissors, nail files, paper cutters, forks, nails, even pens and sharp-pointed pencils, should be kept out of reach, and likewise all poisonous substances. If the patient wants to write, be sure that he is supplied with a pencil whose point is so blunt that no danger could come from it.

If the patient has succeeded in making an attempt at suicide by strangulation or suffocation, remove him to the open air as soon as possible and apply artificial respiration, according to any one of the well-known methods. An important point in the use of artificial respiration is that it should always be kept up for at least one hour, for there are patients, apparently dead, who recover only after forty-five minutes to one hour of steady work. In cases of poisoning, simple emetic mixtures such as warm water, soap and water, or mustard and water may be administered before the physician arrives. Then gastric lavage may be done and specific antidotes given. Personal injury calls only for general surgical principles.

INSURANCE NURSING IN ROCHESTER.

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This nursing service is for the benefit of the industrial policy-holder only. Industrial insurance is a system of weekly-payment insurance; it is adapted, therefore, to the necessities of the working man. By organizing a nursing service the insurance company finds a